Illinois Department of Insurance

Physician Certification
Experimental/Investigational Review

320 West Washington Street
Springfield, IL 62767
Toll- Free 877-850-4740
TDD: 866-323-5321
Fax: 217-557-8495

DOI.externalreview@illinois.gov

Revised 3/2020

This form must accompany the "Request for External Review" form

This form is to be completed by the treating physician as a supplement to the Request for External Review form when the patient has been denied a health care service or course of treatment on the basis that the drug, procedure, therapy or service has been determined to be experimental and/or investigational.

PATIENT		
Last	**First**	**MI**

HEALTH CARE PROVIDER INFORMATION			
Treating Health Care Provider Name	**Licensure & Area of Clinical Specialty**		
Address	**City**	**State**	**Zip**
Contact Person	**Phone**		
Email	**Fax**		

1. The patient has a condition that qualifies under one or more of the following: Check all that apply. (must check one)

☐ Standard health care services or treatments have not been effective in improving the patient's condition

☐ Standard health care services or treatments are not medically appropriate for the patient

☐ There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the requested or recommended health care service or treatment.

2. Check all that apply. (must check one)

☐ The health care service or treatment I have recommended and which has been denied, in my medical opinion, is likely to be more beneficial to the patient than any available standard health care services or treatments.

☐ It is my medical opinion based on scientifically valid studies using accepted protocols that the health care service or treatment requested by the patient and which has been denied is likely to be more beneficial to the patient than any available health care services or treatment.

Please describe the procedure, treatment or drug that is being denied and why you disagree

Please provide a description of the recommended or requested health care service or treatment that is the subject of this denial.

I hereby certify that I am the treating health care provider for the patient named above in this external review and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the health carrier's determination that the proposed therapy is experimental and/or investigational. I understand that in order for the patient to obtain the right to an external review of this denial, as the treating provider I must certify that the patient's medical condition meets certain requirements as shown in this form.

Health Care Signature_____ **Date**_____

Send completed form and any supporting documents to:

Illinois Department of Insurance
Office of Consumer Health Insurance
320 West Washington Street
Springfield, IL 62767

FAX (217)557-8495
Email DOI.externalreview@illinois.gov
Submit on-line at http://insurance.illinois.gov
Toll-free Consumer Hotline: 877-850-4740
TDD - 866-323-5321

Submit Form